

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please fill in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, please remove carbon paper. Please send it to the State Dept. of Health and Mental Hygiene (attn: Director of Burial) immediately, or return it to the hospital or attending physician.

IMPORTANT: If item 23 is marked or item 24 shows any injury or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 7 30 531											
1 - STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
SUSIE LOUISE BOSWELL						October 26, 1987				1:00 AM	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11-10-1899			6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7 UNDER-1 YEAR MONTH DAY HOUR MIN		
7a. BIRTHPLACE COUNTRY Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.				
10 CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Hotel				
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 188A Dockser Dr/Rt. 2/20659			
14. FATHER'S NAME FIRST unavailable		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST unavailable			MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO --		17. INFORMANT ADDRESS Edward L. Boswell same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)											
DOUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Congestive heart failure, Electrolyte imbalance</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b PART I OR PART II)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/23/82</u> , 19 <u>82</u> , to <u>10/25</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE 		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>10-26-87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Nayan R. Shah, M.D.</u>		22e. ADDRESS <u>RT 2, Box 288 Leonardtown, Md. 20650</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-29-87		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home		ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR <u>OCT 28 1987</u>			25b. REGISTRAR'S SIGNATURE <u>John R. Kendall</u>				

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
EDWARD RAY BURROUGHS						Oct. 24, 1987				3:45 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 14 yrs	
MALE		WHITE		MONTH DEC. DAY 26, 1890 YEAR		96 YRS		YR		MTH DYS	
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8		9 BALTIMORE CITY OR COUNTY OF DEATH		St. Mary's County MD.			
MD.		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital				FARMER		FARM			
13a STATE MD.		13b COUNTY ST. MARY'S		13c CITY OR TOWN MECHANICSVILLE		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE RT. 4, BOX 469/20659			
14 FATHER'S NAME FIRST EDWARD		MIDDLE LUTHER		LAST BURROUGHS		15 MOTHER'S MAIDEN NAME FIRST ALICE		MIDDLE LAST BURROUGHS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-5953		17 INFORMANT		ADDRESS		RT. 3, BOX 20 WARREN H. BURROUGHS, MECHANICSVILLE, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Auto septic shock with suggested pneumonia</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Obstruction airway + acute Renal Failure</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c HOW INJURY OCCURRED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c		ENTER NUMBER OF INJURY IN ITEM 2b PART 1 OR PART 2					
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (i) (this hospital) attended the deceased from <i>10/21</i> , 19 <i>87</i> to <i>10/24</i> , 19 <i>87</i> that (ii) (we) last saw the deceased alive on <i>10/23</i> , 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) view the body after death											
22b SIGNATURE						DEGREE					
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <i>10/25/87</i>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>James C. Boyd, M.D.</i>						22e ADDRESS Leonardtown, Md. 20650					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE BURIAL 10-26-87		23c NAME OF CEMETERY OR CREMATORIUM ALL FAITH CHURCH CEM.		23d LOCATION CITY OR TOWN CHARLOTTE HALL, ST. M., MD.					
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		ADDRESS OCT 27 1987		25a DATE REC'D BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transmit permit. Then please return entire papers (Pages 1 and 2) to the office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified and examined.

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SPECIAL
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3033
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST HENRY	MIDDLE PRESTON	LAST BURROUGHS	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/>	MONTH YEAR	DAY YEAR	2b HOUR MIN			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH NOV. YEAR 1960	6. AGE IN YEARS LAST BIRTHDAY 26 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD 10-15-87	2d HOUR 7:18a				
7a BIRTHPLACE COUNTRY WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S COUNTY					
10. CITY OR TOWN OF DEATH MECHANICSVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) Rt. 236, 1 mile E. of Stauffers/Mill		12a USUAL OCCUPATION FOR MOST OF WORKING LIFE Sawyer		12b KIND OF BUSINESS OR INDUSTRY PEPCO					
13a STATE MARYLAND	13b COUNTY ST. MARY'S	13c CITY OR TOWN MECHANICSVILLE	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET ADDRESS OLD RT. 5	14. FATHER'S NAME FIRST BENJAMIN	MIDDLE BURROUGHS, JR.	LAST JOAN	15. MOTHER'S MAIDEN NAME FIRST VICTORIA	MIDDLE HEWITT	LAST ADDRESS P.O. BOX 207 BENJAMIN BURROUGHS, JR., MECHANICSVILLE, MD	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-72-7927		17. INFORMANT BENJAMIN BURROUGHS, JR.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY Head and neck injuries IMMEDIATE CAUSE (a) 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:20am 10-15-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) driver of an auto who struck a horse/fixed object and overturning							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) hwy.		21f LOCATION STREET Rt. 236, 1 mile E. of St. Mary's Co., Md.							
22a I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion							
ACTUAL SIGNATURE <i>Margarita Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street		DATE 10-15-87 SIGNED							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10/17/87		23c NAME OF CEMETERY OR CREMATORIAL ALL FAITH							
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		ADDRESS		25a DATE REC'D. BY REGISTRAR OCT 21 1987							
				25b REGISTRAR'S SIGNATURE <i>Jane Davidson-Pandell</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician or by a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached from use as the burial transit permit. Then please affix this paper to the papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or removal.

IMPORTANT: If Item 21 is marked with a checkmark, show any injury, or other traumatic event, the medical certificate must be signed by the attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 7 3053	
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
WEBSTER GIBBONS CHASE						October 7, 1987	3:16A M
3 SEX	4 RACE	5 DATE OF BIRTH					
MALE	BLACK	MONTH NOV. DAY 11, YEAR 1915					
7a BIRTHPLACE STATE OR FOREIGN COUNTRY MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.				
10 CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JANITOR	12b KIND OF BUSINESS OR INDUSTRY SCHOOL		
13a STATE MD.	13b COUNTY ST. MARY'S	13c CITY OR TOWN LEXINGTON PARK	13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE P.O. BOX 180C/20653			
14 FATHER'S NAME FIRST WILLIAM	MIDDLE HENRY	LAST CHASE	15 MOTHER'S MAIDEN NAME ANNIE	16 ADDRESS LEXINGTON PARK, MD.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) NO	16b SOCIAL SECURITY NO. 220-05-3276	17 INFORMANT LAWRENCE V. CHASE RT. 4, BOX 17.	18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (b) <u>Carcinomatosis</u> BETWEEN ONSET AND DEATH underlying cause lost (c) <u>Carcinoma of Mastoid</u> wks. months				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a							
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a I certify that (1) the physician attended the deceased from saw the deceased alive on 10/6/87, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (2) I did not view the body after death.	19 85 to 10/7 19 87 that I last						
22b SIGNATURE <i>J. Patrick Jarboe M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e ADDRESS Leonardtown. Md. 20650				
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS Leonardtown. Md. 20650						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-15-87	23c NAME OF CEMETERY OR CREMATORIUM IMMACULATE HEART OF MARY CEMETERY	23d LOCATION CITY OR TOWN LEXINGTON PARK, ST. M. MD.	23e DATE SIGNED 10/7/87			
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.	25a DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE OCT 13 1987						

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 30535
1 DECEASED NAME (TYPE OR PRINT) BERTHA Elizabeth COLLIER				2a DATE OF DEATH MONTH DAY YEAR 10/4/87				2b HOUR 8:15 PM		
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 10 17 1910		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 76 YRS		7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 8 15 00 00		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County		MD.		
10 CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Nursing Center		12a USUAL OCCUPATION BEAUTICIAN		12b KIND OF BUSINESS OR INDUSTRY HAIR				
13a STATE MD.		13b COUNTY ST. MARY'S		13c CITY OR TOWN CHARLOTTE HALL		13d INSIDE CITY LIMITS? NO		13e STREET ADDRESS OLD RT. 5 / 20622		
14 FATHER'S NAME FIRST WALTER		MIDDLE R.		LAST HOCHADAY		15 MOTHER'S MAIDEN NAME FIRST EMMA		MIDDLE ALLEN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 579-09-7193		17 INFORMANT A, EMMA LOUISE ALLIO, SAME AS 13E.		ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriovenous accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Arteriosclerosis</i>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (1) this hospital attended the deceased from May 84 to Oct 4 87 , that (2) we last saw the deceased alive on Oct 4 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we did (did not) view the body after death.										22c DATE SIGNED 10/4/87
22b SIGNATURE <i>YOUNGSIK MOON, M.D.</i>		22c DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d PHYSICIAN'S NAME (TYPE OR PRINT) YOUNGSIK MOON, M.D.		22e ADDRESS HOLLYWOOD, MD. 20636								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-7-87		23c NAME OF CEMETERY OR CREMATORIAL CHELTONHAM VETERANS		23d LOCATION CITY OR TOWN CHELTONHAM, P.G.		STATE MD.		
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		25a DATE REC'D. BY REGISTRAR OCT 8 1987				25b REGISTRAR'S SIGNATURE <i>Julia Deacon-Readers</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. 30333

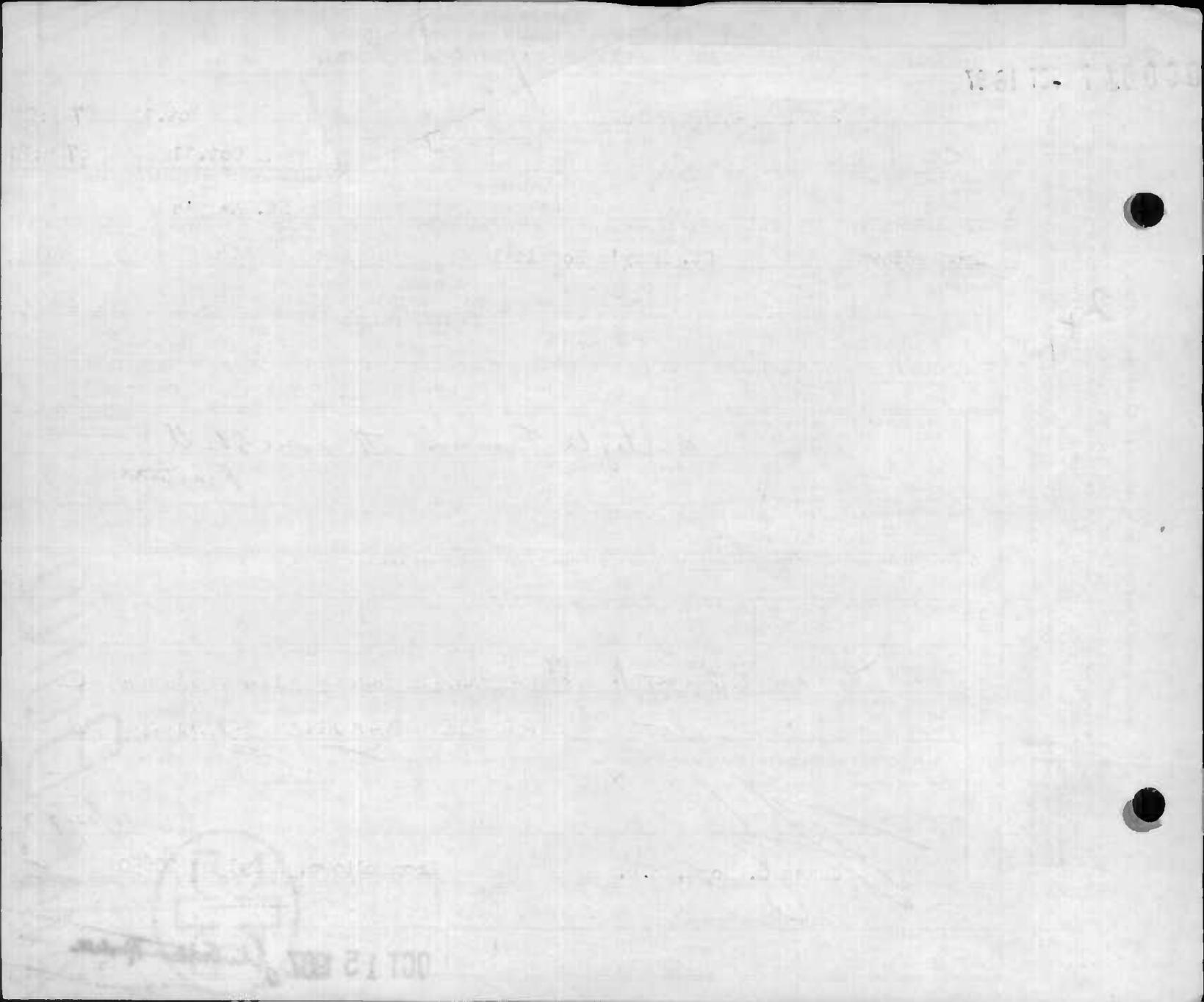
1 - DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
VERONICA DVORSACK DEMKO						OCTOBER	9,	1987		10:15PM	
3 SEX	4 RACE	5 DATE OF BIRTH			MONTH	DAY	YEAR				
FEMALE	CAUCASIAN	JUNE 25, 1899			JUNE	25	1899				
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8			MARRIED	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	DIVORCED	<input checked="" type="checkbox"/>	
CZECHOSLOVAKIA	U.S.A.										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
LEXINGTON PARK	BAYSIDE NURSING CENTER					HOMEMAKER			MD		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			GENERAL DELIVERY 20628		
MARYLAND	ST. MARY'S	DAMERON	YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>	RT. # 235, DAMERON, MARYLAND				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	KOLLAR	
STEVE			DVORSACK	ANNA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO	213-74-1096			JOSEPH DEMKO, JR.			GENERAL DELIVERY, RT# 235 DAMERON, MARYLAND 20628				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (b) <u>Compulsive Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Organic Brain Syndrome</u>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE
22a. I certify that (I) (this hospital) attended the deceased from 10-16 1978 to 8-27 1987 that (I) (we) last saw the deceased alive on 8-27 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 	DEGREE	ATTENDING PHYSICIAN	<input checked="" type="checkbox"/>	MEDICAL DIRECTOR	<input type="checkbox"/>	STAFF PHYSICIAN	<input type="checkbox"/>	22c. DATE SIGNED 10-12-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ADINATH A. PATIL, MD.	22e. ADDRESS 20650	SHANTI MEDICAL CENTER, LEONARDTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10-13-87	23c. NAME OF CEMETERY OR CREMATORIAL SLOVAK FARMERS CEMETERY	23d. LOCATION CITY OR TOWN ST. MARY'S CITY, ST. MARY'S	MARYLAND							
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR. LEONARDTOWN, MD.	25a. DATE REC'D. BY REGISTRAR OCT 16 1987			25b. REGISTRAR'S SIGNATURE 							

10 01 100 10100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL ON ITEM 18, GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-2, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 30537					
1- STATE REGISTRAR		FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI. DEATH MATED		MONTH DAY YEAR	2b HOUR	
REASSED NAME (TYPE OR PRINT)											<input type="checkbox"/>		Oct. 11 19 87	9:21	
JAMES BERNARD EDWARDS											<input type="checkbox"/>		Oct. 11 19 87	9:21	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d HOUR
Oct. 19, 1941		45 yrs.										Oct. 11 19 87			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's				
10 CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer			12b KIND OF BUSINESS OR INDUSTRY D.C. Gov't.							
13a STATE Maryland		13b COUNTY Charles		13c CITY OR TOWN Waldorf		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 5001 Albacore Court 20601							
14 FATHER'S NAME FIRST Albert		MIDDLE W.		LAST Edwards		15 MOTHER'S MAIDEN NAME FIRST Louise		MIDDLE K.		LAST Harbridge					
16a WAS DECESSED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. Vietnam		16c		17 INFORMANT Milagros L. Edwards same as 13		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multile Trauma with severe skull fracture</i> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:28 P.M. OCT 11 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>PASSENGER Thrown From Automobile</i>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>STREET</i>		21f LOCATION STREET RT 235 CITY OR TOWN OAKVILLE, ST. MARY'S, Md.		CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the deceased described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural death <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>JAMES C. Boyd, M.D.</i>										TITLE (SPECIFY) M.D. MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) James C. Boyd, M.D.										DATE SIGNED 10/12/87					
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b DATE Oct. 15, 1987		23c NAME OF CEMETERY OR CREMATORIAL Md. Vet. Cemetery		23d LOCATION CITY OR TOWN Cheltenham, P.G., Maryland		COUNTY STATE							
24 FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS P.O. Box 156		25a DATE REC'D. BY REGISTRAR OCT 15 1987		25b REGISTRAR'S SIGNATURE <i>Julia Saunders Pendell</i>									
ADDRESS Waldorf, Md. 20601															
DHMH 17 VRA 15 ME (5) 20M 4-82															



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 30538

068725 OCT 15 87
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH.
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1A, 1B, 1C, 1D, 1E, 1F, 1G, 1H, 1I, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1R, 1S, 1T, 1U, 1V, 1W, 1X, 1Y, 1Z, 2A, 2B, 2C, 2D, 2E, 2F, 2G, 2H, 2I, 2J, 2K, 2L, 2M, 2N, 2O, 2P, 2Q, 2R, 2S, 2T, 2U, 2V, 2W, 2X, 2Y, 2Z, 3A, 3B, 3C, 3D, 3E, 3F, 3G, 3H, 3I, 3J, 3K, 3L, 3M, 3N, 3O, 3P, 3Q, 3R, 3S, 3T, 3U, 3V, 3W, 3X, 3Y, 3Z, 4A, 4B, 4C, 4D, 4E, 4F, 4G, 4H, 4I, 4J, 4K, 4L, 4M, 4N, 4O, 4P, 4Q, 4R, 4S, 4T, 4U, 4V, 4W, 4X, 4Y, 4Z, 5A, 5B, 5C, 5D, 5E, 5F, 5G, 5H, 5I, 5J, 5K, 5L, 5M, 5N, 5O, 5P, 5Q, 5R, 5S, 5T, 5U, 5V, 5W, 5X, 5Y, 5Z, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 6I, 6J, 6K, 6L, 6M, 6N, 6O, 6P, 6Q, 6R, 6S, 6T, 6U, 6V, 6W, 6X, 6Y, 6Z, 7A, 7B, 7C, 7D, 7E, 7F, 7G, 7H, 7I, 7K, 7L, 7M, 7N, 7O, 7P, 7Q, 7R, 7S, 7T, 7U, 7V, 7W, 7X, 7Y, 7Z, 8A, 8B, 8C, 8D, 8E, 8F, 8G, 8H, 8I, 8J, 8K, 8L, 8M, 8N, 8O, 8P, 8Q, 8R, 8S, 8T, 8U, 8V, 8W, 8X, 8Y, 8Z, 9A, 9B, 9C, 9D, 9E, 9F, 9G, 9H, 9I, 9J, 9K, 9L, 9M, 9N, 9O, 9P, 9Q, 9R, 9S, 9T, 9U, 9V, 9W, 9X, 9Y, 9Z, 10A, 10B, 10C, 10D, 10E, 10F, 10G, 10H, 10I, 10K, 10L, 10M, 10N, 10O, 10P, 10Q, 10R, 10S, 10T, 10U, 10V, 10W, 10X, 10Y, 10Z, 11A, 11B, 11C, 11D, 11E, 11F, 11G, 11H, 11I, 11K, 11L, 11M, 11N, 11O, 11P, 11Q, 11R, 11S, 11T, 11U, 11V, 11W, 11X, 11Y, 11Z, 12A, 12B, 12C, 12D, 12E, 12F, 12G, 12H, 12I, 12K, 12L, 12M, 12N, 12O, 12P, 12Q, 12R, 12S, 12T, 12U, 12V, 12W, 12X, 12Y, 12Z, 13A, 13B, 13C, 13D, 13E, 13F, 13G, 13H, 13I, 13K, 13L, 13M, 13N, 13O, 13P, 13Q, 13R, 13S, 13T, 13U, 13V, 13W, 13X, 13Y, 13Z, 14A, 14B, 14C, 14D, 14E, 14F, 14G, 14H, 14I, 14K, 14L, 14M, 14N, 14O, 14P, 14Q, 14R, 14S, 14T, 14U, 14V, 14W, 14X, 14Y, 14Z, 15A, 15B, 15C, 15D, 15E, 15F, 15G, 15H, 15I, 15K, 15L, 15M, 15N, 15O, 15P, 15Q, 15R, 15S, 15T, 15U, 15V, 15W, 15X, 15Y, 15Z, 16A, 16B, 16C, 16D, 16E, 16F, 16G, 16H, 16I, 16K, 16L, 16M, 16N, 16O, 16P, 16Q, 16R, 16S, 16T, 16U, 16V, 16W, 16X, 16Y, 16Z, 17A, 17B, 17C, 17D, 17E, 17F, 17G, 17H, 17I, 17K, 17L, 17M, 17N, 17O, 17P, 17Q, 17R, 17S, 17T, 17U, 17V, 17W, 17X, 17Y, 17Z, 18A, 18B, 18C, 18D, 18E, 18F, 18G, 18H, 18I, 18K, 18L, 18M, 18N, 18O, 18P, 18Q, 18R, 18S, 18T, 18U, 18V, 18W, 18X, 18Y, 18Z, 19A, 19B, 19C, 19D, 19E, 19F, 19G, 19H, 19I, 19K, 19L, 19M, 19N, 19O, 19P, 19Q, 19R, 19S, 19T, 19U, 19V, 19W, 19X, 19Y, 19Z, 20A, 20B, 20C, 20D, 20E, 20F, 20G, 20H, 20I, 20K, 20L, 20M, 20N, 20O, 20P, 20Q, 20R, 20S, 20T, 20U, 20V, 20W, 20X, 20Y, 20Z, 21A, 21B, 21C, 21D, 21E, 21F, 21G, 21H, 21I, 21K, 21L, 21M, 21N, 21O, 21P, 21Q, 21R, 21S, 21T, 21U, 21V, 21W, 21X, 21Y, 21Z, 22A, 22B, 22C, 22D, 22E, 22F, 22G, 22H, 22I, 22K, 22L, 22M, 22N, 22O, 22P, 22Q, 22R, 22S, 22T, 22U, 22V, 22W, 22X, 22Y, 22Z, 23A, 23B, 23C, 23D, 23E, 23F, 23G, 23H, 23I, 23K, 23L, 23M, 23N, 23O, 23P, 23Q, 23R, 23S, 23T, 23U, 23V, 23W, 23X, 23Y, 23Z, 24A, 24B, 24C, 24D, 24E, 24F, 24G, 24H, 24I, 24K, 24L, 24M, 24N, 24O, 24P, 24Q, 24R, 24S, 24T, 24U, 24V, 24W, 24X, 24Y, 24Z, 25A, 25B, 25C, 25D, 25E, 25F, 25G, 25H, 25I, 25K, 25L, 25M, 25N, 25O, 25P, 25Q, 25R, 25S, 25T, 25U, 25V, 25W, 25X, 25Y, 25Z, 26A, 26B, 26C, 26D, 26E, 26F, 26G, 26H, 26I, 26K, 26L, 26M, 26N, 26O, 26P, 26Q, 26R, 26S, 26T, 26U, 26V, 26W, 26X, 26Y, 26Z, 27A, 27B, 27C, 27D, 27E, 27F, 27G, 27H, 27I, 27K, 27L, 27M, 27N, 27O, 27P, 27Q, 27R, 27S, 27T, 27U, 27V, 27W, 27X, 27Y, 27Z, 28A, 28B, 28C, 28D, 28E, 28F, 28G, 28H, 28I, 28K, 28L, 28M, 28N, 28O, 28P, 28Q, 28R, 28S, 28T, 28U, 28V, 28W, 28X, 28Y, 28Z, 29A, 29B, 29C, 29D, 29E, 29F, 29G, 29H, 29I, 29K, 29L, 29M, 29N, 29O, 29P, 29Q, 29R, 29S, 29T, 29U, 29V, 29W, 29X, 29Y, 29Z, 30A, 30B, 30C, 30D, 30E, 30F, 30G, 30H, 30I, 30K, 30L, 30M, 30N, 30O, 30P, 30Q, 30R, 30S, 30T, 30U, 30V, 30W, 30X, 30Y, 30Z, 31A, 31B, 31C, 31D, 31E, 31F, 31G, 31H, 31I, 31K, 31L, 31M, 31N, 31O, 31P, 31Q, 31R, 31S, 31T, 31U, 31V, 31W, 31X, 31Y, 31Z, 32A, 32B, 32C, 32D, 32E, 32F, 32G, 32H, 32I, 32K, 32L, 32M, 32N, 32O, 32P, 32Q, 32R, 32S, 32T, 32U, 32V, 32W, 32X, 32Y, 32Z, 33A, 33B, 33C, 33D, 33E, 33F, 33G, 33H, 33I, 33K, 33L, 33M, 33N, 33O, 33P, 33Q, 33R, 33S, 33T, 33U, 33V, 33W, 33X, 33Y, 33Z, 34A, 34B, 34C, 34D, 34E, 34F, 34G, 34H, 34I, 34K, 34L, 34M, 34N, 34O, 34P, 34Q, 34R, 34S, 34T, 34U, 34V, 34W, 34X, 34Y, 34Z, 35A, 35B, 35C, 35D, 35E, 35F, 35G, 35H, 35I, 35K, 35L, 35M, 35N, 35O, 35P, 35Q, 35R, 35S, 35T, 35U, 35V, 35W, 35X, 35Y, 35Z, 36A, 36B, 36C, 36D, 36E, 36F, 36G, 36H, 36I, 36K, 36L, 36M, 36N, 36O, 36P, 36Q, 36R, 36S, 36T, 36U, 36V, 36W, 36X, 36Y, 36Z, 37A, 37B, 37C, 37D, 37E, 37F, 37G, 37H, 37I, 37K, 37L, 37M, 37N, 37O, 37P, 37Q, 37R, 37S, 37T, 37U, 37V, 37W, 37X, 37Y, 37Z, 38A, 38B, 38C, 38D, 38E, 38F, 38G, 38H, 38I, 38K, 38L, 38M, 38N, 38O, 38P, 38Q, 38R, 38S, 38T, 38U, 38V, 38W, 38X, 38Y, 38Z, 39A, 39B, 39C, 39D, 39E, 39F, 39G, 39H, 39I, 39K, 39L, 39M, 39N, 39O, 39P, 39Q, 39R, 39S, 39T, 39U, 39V, 39W, 39X, 39Y, 39Z, 40A, 40B, 40C, 40D, 40E, 40F, 40G, 40H, 40I, 40K, 40L, 40M, 40N, 40O, 40P, 40Q, 40R, 40S, 40T, 40U, 40V, 40W, 40X, 40Y, 40Z, 41A, 41B, 41C, 41D, 41E, 41F, 41G, 41H, 41I, 41K, 41L, 41M, 41N, 41O, 41P, 41Q, 41R, 41S, 41T, 41U, 41V, 41W, 41X, 41Y, 41Z, 42A, 42B, 42C, 42D, 42E, 42F, 42G, 42H, 42I, 42K, 42L, 42M, 42N, 42O, 42P, 42Q, 42R, 42S, 42T, 42U, 42V, 42W, 42X, 42Y, 42Z, 43A, 43B, 43C, 43D, 43E, 43F, 43G, 43H, 43I, 43K, 43L, 43M, 43N, 43O, 43P, 43Q, 43R, 43S, 43T, 43U, 43V, 43W, 43X, 43Y, 43Z, 44A, 44B, 44C, 44D, 44E, 44F, 44G, 44H, 44I, 44K, 44L, 44M, 44N, 44O, 44P, 44Q, 44R, 44S, 44T, 44U, 44V, 44W, 44X, 44Y, 44Z, 45A, 45B, 45C, 45D, 45E, 45F, 45G, 45H, 45I, 45K, 45L, 45M, 45N, 45O, 45P, 45Q, 45R, 45S, 45T, 45U, 45V, 45W, 45X, 45Y, 45Z, 46A, 46B, 46C, 46D, 46E, 46F, 46G, 46H, 46I, 46K, 46L, 46M, 46N, 46O, 46P, 46Q, 46R, 46S, 46T, 46U, 46V, 46W, 46X, 46Y, 46Z, 47A, 47B, 47C, 47D, 47E, 47F, 47G, 47H, 47I, 47K, 47L, 47M, 47N, 47O, 47P, 47Q, 47R, 47S, 47T, 47U, 47V, 47W, 47X, 47Y, 47Z, 48A, 48B, 48C, 48D, 48E, 48F, 48G, 48H, 48I, 48K, 48L, 48M, 48N, 48O, 48P, 48Q, 48R, 48S, 48T, 48U, 48V, 48W, 48X, 48Y, 48Z, 49A, 49B, 49C, 49D, 49E, 49F, 49G, 49H, 49I, 49K, 49L, 49M, 49N, 49O, 49P, 49Q, 49R, 49S, 49T, 49U, 49V, 49W, 49X, 49Y, 49Z, 50A, 50B, 50C, 50D, 50E, 50F, 50G, 50H, 50I, 50K, 50L, 50M, 50N, 50O, 50P, 50Q, 50R, 50S, 50T, 50U, 50V, 50W, 50X, 50Y, 50Z, 51A, 51B, 51C, 51D, 51E, 51F, 51G, 51H, 51I, 51K, 51L, 51M, 51N, 51O, 51P, 51Q, 51R, 51S, 51T, 51U, 51V, 51W, 51X, 51Y, 51Z, 52A, 52B, 52C, 52D, 52E, 52F, 52G, 52H, 52I, 52K, 52L, 52M, 52N, 52O, 52P, 52Q, 52R, 52S, 52T, 52U, 52V, 52W, 52X, 52Y, 52Z, 53A, 53B, 53C, 53D, 53E, 53F, 53G, 53H, 53I, 53K, 53L, 53M, 53N, 53O, 53P, 53Q, 53R, 53S, 53T, 53U, 53V, 53W, 53X, 53Y, 53Z, 54A, 54B, 54C, 54D, 54E, 54F, 54G, 54H, 54I, 54K, 54L, 54M, 54N, 54O, 54P, 54Q, 54R, 54S, 54T, 54U, 54V, 54W, 54X, 54Y, 54Z, 55A, 55B, 55C, 55D, 55E, 55F, 55G, 55H, 55I, 55K, 55L, 55M, 55N, 55O, 55P, 55Q, 55R, 55S, 55T, 55U, 55V, 55W, 55X, 55Y, 55Z, 56A, 56B, 56C, 56D, 56E, 56F, 56G, 56H, 56I, 56K, 56L, 56M, 56N, 56O, 56P, 56Q, 56R, 56S, 56T, 56U, 56V, 56W, 56X, 56Y, 56Z, 57A, 57B, 57C, 57D, 57E, 57F, 57G, 57H, 57I, 57K, 57L, 57M, 57N, 57O, 57P, 57Q, 57R, 57S, 57T, 57U, 57V, 57W, 57X, 57Y, 57Z, 58A, 58B, 58C, 58D, 58E, 58F, 58G, 58H, 58I, 58K, 58L, 58M, 58N, 58O, 58P, 58Q, 58R, 58S, 58T, 58U, 58V, 58W, 58X, 58Y, 58Z, 59A, 59B, 59C, 59D, 59E, 59F, 59G, 59H, 59I, 59K, 59L, 59M, 59N, 59O, 59P, 59Q, 59R, 59S, 59T, 59U, 59V, 59W, 59X, 59Y, 59Z, 60A, 60B, 60C, 60D, 60E, 60F, 60G, 60H, 60I, 60K, 60L, 60M, 60N, 60O, 60P, 60Q, 60R, 60S, 60T, 60U, 60V, 60W, 60X, 60Y, 60Z, 61A, 61B, 61C, 61D, 61E, 61F, 61G, 61H, 61I, 61K, 61L, 61M, 61N, 61O, 61P, 61Q, 61R, 61S, 61T, 61U, 61V, 61W, 61X, 61Y, 61Z, 62A, 62B, 62C, 62D, 62E, 62F, 62G, 62H, 62I, 62K, 62L, 62M, 62N, 62O, 62P, 62Q, 62R, 62S, 62T, 62U, 62V, 62W, 62X, 62Y, 62Z, 63A, 63B, 63C, 63D, 63E, 63F, 63G, 63H, 63I, 63K, 63L, 63M, 63N, 63O, 63P, 63Q, 63R, 63S, 63T, 63U, 63V, 63W, 63X, 63Y, 63Z, 64A, 64B, 64C, 64D, 64E, 64F, 64G, 64H, 64I, 64K, 64L, 64M, 64N, 64O, 64P, 64Q, 64R, 64S, 64T, 64U, 64V, 64W, 64X, 64Y, 64Z, 65A, 65B, 65C, 65D, 65E, 65F, 65G, 65H, 65I, 65K, 65L, 65M, 65N, 65O, 65P, 65Q, 65R, 65S, 65T, 65U, 65V, 65W, 65X, 65Y, 65Z, 66A, 66B, 66C, 66D, 66E, 66F, 66G, 66H, 66I, 66K, 66L, 66M, 66N, 66O, 66P, 66Q, 66R, 66S, 66T, 66U, 66V, 66W, 66X, 66Y, 66Z, 67A, 67B, 67C, 67D, 67E, 67F, 67G, 67H, 67I, 67K, 67L, 67M, 67N, 67O, 67P, 67Q, 67R, 67S, 67T, 67U, 67V, 67W, 67X, 67Y, 67Z, 68A, 68B, 68C, 68D, 68E, 68F, 68G, 68H, 68I, 68K, 68L, 68M, 68N, 68O, 68P, 68Q, 68R, 68S, 68T, 68U, 68V, 68W, 68X, 68Y, 68Z, 69A, 69B, 69C, 69D, 69E, 69F, 69G, 69H, 69I, 69K, 69L, 69M, 69N, 69O, 69P, 69Q, 69R, 69S, 69T, 69U, 69V, 69W, 69X, 69Y, 69Z, 70A, 70B, 70C, 70D, 70E, 70F, 70G, 70H, 70I, 70K, 70L, 70M, 70N, 70O, 70P, 70Q, 70R, 70S, 70T, 70U, 70V, 70W, 70X, 70Y, 70Z, 71A, 71B, 71C, 71D, 71E, 71F, 71G, 71H, 71I, 71K, 71L, 71M, 71N, 71O, 71P, 71Q, 71R, 71S, 71T, 71U, 71V, 71W, 71X, 71Y, 71Z, 72A, 72B, 72C, 72D, 72E, 72F, 72G, 72H, 72I, 72K, 72L, 72M, 72N, 72O, 72P, 72Q, 72R, 72S, 72T, 72U, 72V, 72W, 72X, 72Y, 72Z, 73A, 73B, 73C, 73D, 73E, 73F, 73G, 73H, 73I, 73K, 73L, 73M, 73N, 73O, 73P, 73Q, 73R, 73S, 73T, 73U, 73V, 73W, 73X, 73Y, 73Z, 74A, 74B, 74C, 74D, 74E, 74F, 74G, 74H, 74I, 74K, 74L, 74M, 74N, 74O, 74P, 74Q, 74R, 74S, 74T, 74U, 74V, 74W, 74X, 74Y, 74Z, 75A, 75B, 75C, 75D, 75E, 75F, 75G, 75H, 75I, 75K, 75L, 75M, 75N, 75O, 75P, 75Q, 75R, 75S, 75T, 75U, 75V, 75W, 75X, 75Y, 75Z, 76A, 76B, 76C, 76D, 76E, 76F, 76G, 76H, 76I, 76K, 76L, 76M, 76N, 76O, 76P, 76Q, 76R, 76S, 76T, 76U, 76V, 76W, 76X, 76Y, 76Z, 77A, 77B, 77C, 77D, 77E, 77F, 77G, 77H, 77I, 77K, 77L, 77M, 77N, 77O, 77P, 77Q, 77R, 77S, 77T, 77U, 77V, 77W, 77X, 77Y, 77Z, 78A, 78B, 78C, 78D, 78E, 78F, 78G, 78H, 78I, 78K, 78L, 78M, 78N, 78O, 78P, 78Q, 78R, 78S, 78T, 78U, 78V, 78W, 78X, 78Y, 78Z, 79A, 79B, 79C, 79D, 79E, 79F, 79G, 79H, 79I, 79K, 79L, 79M, 79N, 79O, 79P, 79Q, 79R, 79S, 79T, 79U, 79V, 79W, 79X, 79Y, 79Z, 80A, 80B, 80C, 80D, 80E, 80F, 80G, 80H, 80I, 80K, 80L, 80M, 80N, 80O, 80P, 80Q, 80R, 80S, 80T, 80U, 80V, 80W, 80X, 80Y, 80Z, 81A, 81B, 81C, 81D, 81E, 81F, 81G, 81H, 81I, 81K, 81L, 81M, 81N, 81O, 81P, 81Q, 81R, 81S, 81T, 81U, 81V, 81W, 81X, 81Y, 81Z, 82A, 82B, 82C, 82D, 82E, 82F, 82G, 82H, 82I, 82K, 82L, 82M, 82N, 82O, 82P, 82Q, 82R, 82S, 82T, 82U, 82V, 82W, 82X, 82Y, 82Z, 83A, 83B, 83C, 83D, 83E, 83F, 83G, 83H, 83I, 83K, 83L, 83M, 83N, 83O, 83P, 83Q, 83R, 83S, 83T, 83U, 83V, 83W, 83X, 83Y, 83Z, 84A, 84B, 84C, 84D, 84E, 84F, 84G, 84H, 84I, 84K, 84L, 84M, 84N, 84O, 84P, 84Q, 84R, 84S, 84T, 84U, 84V, 84W, 84X, 84Y, 84Z, 85A, 85B, 85C, 85D, 85E, 85F, 85G, 85H, 85I, 85K, 85L, 85M, 85N, 85O, 85P, 85Q, 85R, 85S, 85T, 85U, 85V, 85W, 85X, 85Y, 85Z, 86A, 86B, 86C, 86D, 86E, 86F, 86G, 86H, 86I, 86K, 86L, 86M, 86N, 86O, 86P, 86Q, 86R, 86S, 86T, 86U, 86V, 86W, 86X, 86Y, 86Z, 87A, 87B, 87C, 87D, 87E, 87F, 87G, 87H, 87I, 87K, 87L, 87M, 87N, 87O, 87P, 87Q, 87R, 87S, 87T, 87U, 87V, 87W, 87X, 87Y, 87Z, 88A, 88B, 88C, 88D, 88E, 88F, 88G, 88H, 88I, 88K, 88L, 88M, 88N, 88O, 88P, 88Q, 88R, 88S, 88T, 88U, 88V, 88W, 88X, 88Y, 88Z, 89A, 89B, 89C, 89D, 89E, 89F, 89G, 89H, 89I, 89K, 89L, 89M, 89N, 89O, 89P, 89Q, 89R, 89S, 89T, 89U, 89V, 89W, 89X, 89Y, 89Z, 90A, 90B, 90C, 90D, 90E, 90F, 90G, 90H, 90I, 90K, 90L, 90M, 90N, 90O, 90P, 90Q, 90R, 90S, 90T, 90U, 90V, 90W, 90X, 90Y, 90Z, 91A, 91B, 91C, 91D, 91E, 91F, 91G, 91H, 91I, 91K, 91L, 91M, 91N, 91O, 91P, 91Q, 91R, 91S, 91T, 91U, 91V, 91W, 91X, 91Y, 91Z, 92A, 92B, 92C, 92D, 92E, 92F, 92G, 92H, 92I, 92K, 92L, 92M, 92N, 92O, 92P, 92Q, 92R, 92S, 92T, 92U, 92V, 92W, 92X, 92Y, 92Z, 93A, 93B, 93C, 93D, 93E, 93F, 93G, 93H, 93I, 93K, 93L, 93M, 93N, 93O, 93P, 93Q, 93R, 93S, 93T, 93U, 93V, 93W, 93X, 93Y, 93Z, 94A, 94B, 94C, 94D, 94E, 94F, 94G, 94H, 94I, 94K, 94L, 94M, 94N, 94O, 94P, 94Q, 94R, 94S, 94T, 94U, 94V, 94W, 94X, 94Y, 94Z, 95A, 95B, 95C, 95D, 95E, 95F, 95G, 95H, 95I, 95K, 95L, 95M, 95N, 95O, 95P, 95Q, 95R, 95S, 95T, 95U, 95V, 95W, 95X, 95Y, 95Z, 96A, 96B, 96C, 96D, 96E, 96F, 96G, 96H, 96I, 96K, 96L, 96M, 96N, 96O, 96P, 96Q, 96R, 96S, 96T, 96U, 96V, 96W, 96X, 96Y, 96Z, 97A, 97B, 97C, 97D, 97E, 97F, 97G, 97H, 97I, 97K, 97L, 97M, 97N, 97O, 97P, 97Q, 97R, 97S, 97T, 97U, 97V, 97W, 97X, 97Y, 97Z, 98A, 98B, 98C, 98D, 98E, 98F, 98G, 98H, 98I, 98K, 98L, 98M, 98N, 98O, 98P, 98Q, 98R, 98S, 98T, 98U, 98V, 98W, 98X, 98Y, 98Z, 99A, 99B, 99C, 99D, 99E, 9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in, it should be delivered to the funeral director. Then please return carbon copies to Roger Ward, 211 State Street, Baltimore, Maryland 21201, or to the State Board of Health and Mental Hygiene, 1800 University Street, Seattle, Washington 98101. If item 21 is marked or if item 18 shows other injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 87 30339									
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR						
	Avonne	Arlene	Green	October 19	1987			2:37A M						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR			8. UNDER 14 YEARS							
Female	Caucasian	May 03 rd 1927	60	MONTH	YRS		MONTH	DAY	HOURS	MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					MD.						
Ridgefield, WA	USA		St. Mary's County											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION					12b. KIND OF BUSINESS OR INDUSTRY					
Patuxent River	Naval Hospital Patuxent River			School Teacher					Montgomery Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS / ZIP CODE					20657				
13a. STATE MD	13b. COUNTY Calvert	13c. CITY OR TOWN Lusby	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	201 Poplar Drive										
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					Harriger				
Gerald G. Parker					Martha									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input type="checkbox"/> NO OR UNKNOWN <input checked="" type="checkbox"/>	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT					ADDRESS							
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Edie Mauer					9222 Wilbur CT. Columbia, MD 21046				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Terminal Pancreatic Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b)									
(c)					DO TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDIC AL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN					COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from 17 OCTOBER, 1987 to 19 OCTOBER, 1987 that (we) last saw the deceased alive on 19 OCTOBER, 1987 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.											22c. DATE SIGNED 19 OCT 87			
22b. SIGNATURE <i>P. Prentice</i>											DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Prentice											... ADDRESS Naval Hospital, Patuxent River, MD 20670			
23a. BURIAL, CREMATION, REMOVAL Cremation	23b. DATE 10-19-1987	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory	23d. LOCATION City or Town Alexandria, Fairfax, Virginia	COUNTY State										
24. FUNERAL DIRECTOR NAME Rt 264, Box 34B, Port Republic, Maryland 20676	ADDRESS	25a. DATE REC'D. BY REGISTRAR OCT 25 1987	25b. REGISTRAR'S SIGNATURE <i>Prentice</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
SELDON LUDLOW HAIGHT						OCTOBER 10, 1987				7:00A M			
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		CAUCASIAN		MARCH 30, 1906			81			MONTHS DAYS			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.			
CONNECTICUT		U.S.A.					ST. MARY'S COUNTY						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
LEONARDTOWN		RT. # 1, BOX 106 D-1		MARINE ENGINEER			M E B A						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS					
MARYLAND		ST. MARY'S		LEONARDTOWN				RT. # 1, BOX 106 D-1			LEONARDTOWN, MARYLAND 20650		
14 FATHER'S NAME FIRST		MIDDLE		LAST	15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
CHARLES		HENRY		HAIGHT	LAURA				DODD				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
YES		1942-1945		492-16-5969		CHRISTINE LATHAN		RT. # 1, BOX 106 D			LEONARDTOWN, MARYLAND		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure.</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) <u>Congestive Heart Failure.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Obstructive Lung Disease</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>87</u> , to <u>9-30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>19-30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Nalini</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-12-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. ADINATH A. PATIL, MD.		22e ADDRESS SHANTI MEDICAL CENTER, LEONARDTOWN, MD.								20650			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-14-87		23c NAME OF CEMETERY OR CREMATORIAL HUNTT CREMATORIAL		23d LOCATION CITY OR TOWN WALDORF		COUNTY CHARLES		STATE MARYLAND			
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.		ADDRESS LEONARDTOWN, MD.		25 DATE RECEIVED BY REGISTRAR OCT 16 1987		26 REGISTRAR'S SIGNATURE <u>Edward Brinsfield</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of the time it is signed.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3054	
1 - STATE REGISTRAR 1 - DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DALLAS FRANKLIN HALL						October 3, 1987				1:15 P.M.	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH APR. 2, 1938	6 AGE (IN YEARS LAST BIRTHDAY) 49	IF UNDER 1 YEAR YRS.	IF UNDER 1 MONTH MONTHS	IF UNDER 1 DAY HOURS	IF UNDER 1 MINUTE MIN.				
7a BIRTHPLACE COUNTRY WASHINGTON, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD								
10 CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital	12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lineman	12b. KIND OF BUSINESS OR INDUSTRY Electric Co.								
13a STATE MD.	13b COUNTY ST. MARY'S	13c CITY OR TOWN MECHANICKSVILLE	13d INSIDE CITY LIMITS? NO	13e STREET ADDRESS / ZIP CODE RT. 3, BOX 415/20659							
14 FATHER'S NAME FIRST CLIFTON	MIDDLE LEE	LAST HALL	15 MOTHER'S MAIDEN NAME FIRST ROSE	MIDDLE A.	LAST WATSON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO	16b SOCIAL SECURITY NO. 219-34-9176	17 INFORMANT NANCY E. HALL, SAME AS 13E	ADDRESS								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Non Hodgkin's Lymphoma</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ Due to, or as a consequence of (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Salt losing Nephropathy</i>											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			19c AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NAME OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	21g CITY OR TOWN	21h COUNTY	21i STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>6/4/87</u> to <u>10/5/87</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b SIGNATURE <u>James C. Boyd, M.D.</u> DEGREE											
22d PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D.					22e ADDRESS Leonardtown, Maryland 20650						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-6-87	23c NAME OF CEMETERY OR CREMATORIAL QUEEN OF PEACE	23d LOCATION CITY OR TOWN HELEN, ST. MARY'S, MD.	23e COUNTY	23f STATE					
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					25a DATE REC'D. BY REGISTRAR OCT 8 1987	25b REGISTRAR'S SIGNATURE <i>June Borden Readace</i>					

WE-120 RAS 030

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30542				
1- STATE REGISTRAR			2a DATE KNOWN OF DEATH ESTIMATED						2b MONTH DAY YEAR		2d HOUR					
1 DECEASED NAME (TYPE OR PRINT)			FIRST JOHN		MIDDLE ARCHIBALD		LAST HILL		<input type="checkbox"/> OCT. 29, 1987		M					
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a IF UNDER 1 YR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN		7c DATE PRONOUNCED DEAD				
MALE		WHITE		MAR. 22, 1918		69 yrs						9 BALTIMORE CITY OR COUNTY OF DEATH				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?						MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ST. MARY'S MD			
U.S.A.																
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION FOR MOST OF WORKING LIFE						12b KIND OF BUSINESS OR INDUSTRY	
LEONARDTOWN			ST. MARY'S HOSPITAL						WAREHOUSEMAN						FURNITURE	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE FLORIDA			13b COUNTY BREVARD			13c CITY OR TOWN MELBOURNE WEST			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 554 JEAN CIRCLE/32904		
14 FATHER'S NAME			FIRST WILLIAM			MIDDLE CHAPMAN			LAST HILL			15 MOTHER'S MAIDEN NAME MARGARET ANN QUADE				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. 579-12-2714A						17 INFORMANT RAYMOND MARIE HILL, SAME AS 13e.		ADDRESS					
NO																
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanotic Cancer Tarynx</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?				
												YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART II OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 10/30/87				
ACTUAL SIGNATURE <i>Wm. Boyd Jr.</i>						TITLE (SPECIFY) M.D. <i>8pt</i>		MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD 11, M.D.			ADDRESS LEONARDTOWN, MD. 20650													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 11-2-87			23c NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEM.			23d LOCATION CITY OR TOWN BUSHWOOD, ST. MARY'S, MD.			COUNTY STATE				
24 FUNERAL DIRECTOR NAME <i>W. Clarke Mattingley</i>			ADDRESS LEONARDTOWN, MD.			25a DATE REC'D. BY REGISTRAR NOV 2 1987			25b REGISTRAR'S SIGNATURE <i>Gilbert Deacon-Pender</i>							
DHMH 17 BP 25M		(VR A15 ME 55)														

U.S.-M-383050



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3054
1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2 DATE OF DEATH	MONTH	DAY	YEAR	7b HOUR		
JOSEPH SPENCER JOHNSON, SR				OCT. 10, 1987				M		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DEC. DAY 20, YEAR 1914	6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN						
7a BIRTHPLACE COUNTRY MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD							
10 CITY OR TOWN OF DEATH MORGANZA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b KIND OF BUSINESS OR INDUSTRY FARMING			
13a STATE MD.	13b COUNTY ST. MARY'S	13c CITY OR TOWN MORGANZA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS GENERAL DELIVERY/20660						
14 FATHER'S NAME FIRST JAMES	MIDDLE CLAUDE	LAST JOHNSON	15 MOTHER'S MAIDEN NAME FIRST MARTHA	MIDDLE MARIE	LAST RUSSELL					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WW11	16b SOCIAL SECURITY NO 41-45	16c PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Motastatic Cancer</u>	17 INFORMANT ADDRESS SUSAN C. JOHNSON, SAME AS 13e.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Motastatic Cancer</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>02 Colon</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery Disease</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN		COUNTY	STATE				
22a I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>A.A. Patil</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED OCT 15 1987					
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS LEONARDTOWN, MD. 20650									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-13-87	23c NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S	23d LOCATION CITY OR TOWN MORGANZA, ST. MARY'S, MD.	23e COUNTY STATE						
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.	25a DATE REC'D. BY REGISTRAR OCT 15 1987	25b REGISTRAR'S SIGNATURE <i>Julie Swanson Pendell</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 30549

1 DECEASED NAME (TYPE OR PRINT)	FIRST THOMAS	MIDDLE CLOONEY	LAST KAFER	2a DATE OF DEATH OCTOBER 4, 1987	MONTH YEAR 7:04 a.m.	2b HOUR 7:04 a.m.
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR AUG. 01, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN.
7a BIRTHPLACE STATE OR FOREIGN COUNTRY NEW JERSEY	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.		
10 CITY OR TOWN OF DEATH LEONARDTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	12b KIND OF BUSINESS OR INDUSTRY CLOTHING	
13a STATE MARYLAND	13b COUNTY ST. MARY'S	13c CITY OR TOWN COMPTON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS ST. CLEMENTS SHORES 20627		
14 FATHER'S NAME FIRST FREDERICK	MIDDLE W.	LAST KAFER	15 MOTHER'S MAIDEN NAME MAUDE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b SOCIAL SECURITY NO. 1942-1945	17 INFORMANT OPAL COX KAFER,	GENERAL DELIVERY COMPTON, MARYLAND 20627			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>METASTATIC lung Cancer</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) _____						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>WILLIAM D. BOYD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/06/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, II, M.D.	22e ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10/7/87	23c NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS	23d LOCATION CITY OR TOWN CHELTENHAM, P.G., MARYLAND	23e COUNTY	STATE	
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	25a DATE REC'D. BY REGISTRAR OCT 09 1987	25b REGISTRAR'S SIGNATURE <i>J. Edward Brinsfield</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3034

1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR										2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			October 20, 1987			9:40 A.M.		
JOSEPH RICHARD POPE														
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR NOV. 1, 1908			6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE COUNTRY WASHINGTON, D.C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD					
10 CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER			12b KIND OF BUSINESS OR INDUSTRY					
13a STATE MD.			13b COUNTY ST. MARY'S			13c CITY OR TOWN LEONARDTOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE RT. 2, BOX 82/20650		
14 FATHER'S NAME JOHN CLINTON POPE						15 MOTHER'S MAIDEN NAME MARY IDA MILLS								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES-ARMY			16b SOCIAL SECURITY NO. W.W.11			17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <i>Metastatic Brain Carcinoma</i>			(c) <i>undetermined primary</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FATHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <i>John F. Fenwick, M.D.</i>			22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED Oct 21 1987					
22d PHYSICIAN'S NAME (TYPE OR PRINT) John F. Fenwick, M.D.			22e ADDRESS Leonardtown, Md. 20650											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 10-23-87			23c NAME OF CEMETERY OR CREMATORIAL ST. FRANCIS XAVIER			23d LOCATION CITY OR TOWN COMPTON, ST. MARY'S, MD.					
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.			25a DATE REC'D. BY REGISTRAR OCT 22 1987			25b REGISTRAR'S SIGNATURE <i>John F. Fenwick, M.D.</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 3030
1 DECEASED NAME (TYPE OR PRINT)	FIRST DOROTHY	MIDDLE LUCILLE	LAST RICHARDS	2a DATE OF DEATH OCT. 11, 1987	2b HOUR M
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR OCT. 27, 1898	6 AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S	MD	
10 CITY OR TOWN OF DEATH VALLEY LEE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) AT HOME, BARDMORE RD.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE'S AID	12b KIND OF BUSINESS OR INDUSTRY HOSPITAL		
13a STATE MD.	13b COUNTY ST. MARY'S	13c CITY OR TOWN VALLEY LEE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS P.O. BOX 135/20692	
14 FATHER'S NAME FIRST CHARLES	MIDDLE HALL	15 MOTHER'S MAIDEN NAME FIRST DOROTHY	MIDDLE K.	LAST BOSWELL	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO 578-66-6071	17 INFORMANT HELEN L. FOSTER, VALLEY LEE, MD. 20692	ADDRESS P.O. BOX 132	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Halligan and Tynglina</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 1984 19 to 10-27-1987			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 80770	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from <u>1984</u> to <u>10-27-1987</u> , that (I) (we) last saw the deceased alive on <u>80770</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b SIGNATURE <i>Wm. D. Boyd</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/2/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, 11. M.D.	22e ADDRESS LEONARDTOWN, MD. 20650				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-13-87	23c NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEM.	23d LOCATION CITY OR TOWN SUITLAND	COUNTY P. G.	STATE MD.
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.	ADDRESS	25a DATE REC'D. BY REGISTRAR OCT 15 1987	25b REGISTRAR'S SIGNATURE <i>Jolie Barker</i>	TYPED	

103130 325880

W.D. & Co.

C. - 500

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W.D. & Co.

103130 325880

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after a patient is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached to use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If Item 18 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 130547		
1 - STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR	
NOV -387		FRANKLIN	THOMAS	RUSSELL	October 29, 1987	6:15AM	
3. SEX		4 RACE	White	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	72 YRS	9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
Leonardtown		St. Mary's Hospital			Farming	Farm	
13a STATE MD.							
13b COUNTY ST. MARY'S		13c CITY OR TOWN Clements		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Gen. Delivery/20624	
14 FATHER'S NAME FIRST		MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST		MIDDLE	
James		Frank	Russell	Annie		Rebecca	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
No		215-02-3419		Johnson B. Wood		Clements, MD. 20624	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Cancer larynx</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2b)			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY
22a I certify that (I) (this hospital) attended the deceased from <i>10/18/87</i> 19 to <i>10/27/87</i> 19, that (I) (we) last saw the deceased alive on <i>10/25/87</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Tom Boyd Jr.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>10/27/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>William D. Boyd, M.D.</i>		22e ADDRESS <i>Leonardtown, Md. 20650</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87	23c NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cem.		23d LOCATION CITY OR TOWN Morganza	COUNTY STM	STATE MD.
24 FUNERAL DIRECTOR NAME <i>W. Clarke Mattingley</i>		ADDRESS <i>Leonardtown, MD.</i>		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <i>Julia Babbitt, Leonardtown</i>	

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAINING PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTIMATED MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b HOUR
ROBERT			WILLIAM	SEWELL, JR.		10	6	19	87	M	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR MONTHS	IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD	<input type="checkbox"/>	MONTH	DAY	YEAR	2d HOUR
MALE	BLACK	AUG. 2, 1949	38 yrs			10	6	19	87	P	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY	7b CITIZEN OF WHAT COUNTRY?	SEPARATED MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County					
10. CITY OR TOWN OF DEATH Patuxent River		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS Patuxent River Hospital				12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE KEY PUNCH OP.					
13a STATE MD.		13b COUNTY ST. MARY'S	13c CITY OR TOWN LEXINGTON PARK	13d INSIDE CITY LIMITS? <input type="checkbox"/>	13e STREET ADDRESS NO <input checked="" type="checkbox"/> 118 CHAPMAN DRIVE/20653	12b KIND OF BUSINESS OR INDUSTRY					
14 FATHER'S NAME FIRST ROBERT		MIDDLE WILLIAM	LAST SEWELL	15 MOTHER'S MAIDEN NAME FIRST GERALDINE	MIDDLE	LAST BROWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO. 212-54-4876		17 INFORMANT GERALDINE F. SEWELL, ST. INIGOES, MD.	ADDRESS 20684						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause</u> lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 								Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. DIXON, M.D.								TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER			
ADDRESS 111 Penn St., Balto., MD 21201								DATE SIGNED 10-7-87			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE BURIAL 10-10-87		23c NAME OF CEMETERY OR CREMATORIUM MT. ZION CEMETERY				23d LOCATION CITY OR TOWN ST. INIGOES, ST. MARY'S, MD.			
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		25a DATE REC'D. BY REGISTRAR OCT 13 1987						25b REGISTRAR'S SIGNATURE 			

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5500 13 730

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

executed by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 30347

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			WILLIAM	L.	SWANN	October 9, 1987				12:30 P	
3. SEX		4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS	IF UNDER 14 HRS MINUTES
MALE		BLACK	JUNE 6, 1915			72					
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.A.						St. Mary's County MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OR NAME FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital			FARMER			FARM			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
MD.		CHARLES		LA PLATA		YES <input type="checkbox"/> NO <input type="checkbox"/>		STAR RT. 5, BOX 475/20646			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. ADDRESS			
				UNKNOWN		MARY		UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)			17 INFORMANT					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		217-36-5834			JAMES F. SWANN,					SAME AS 13E.	
18 CAUSE OF DEATH (Enter only one cause per line for part I(a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Death recurrent systemic unknown state</i> DOUE TO, OR AS A CONSEQUENCE OF (b) _____ DOUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Recurrent Pneumonia, Bronchitis, Doubtless Ulcers</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)						
21d INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN			COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>87</u> to <u>10/9/87</u> , 19____ that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b SIGNATURE		22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED				
22d PHYSICIAN'S NAME							<u>10/10/87</u>				
James C. Boyd, M.D.							Leonardtown, Md. 20650				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL CHARLES MEMORIAL GARDENS			23d LOCATION CITY OR TOWN		COUNTY	STATE	
BURIAL		10-16-87					LEONARDTOWN, ST. MARY'S, MD.				
24 FUNERAL DIRECTOR NAME		ADDRESS			25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					OCT 19 1987		<i>Julie S. Borden-Randall</i>				

100 100 24023

10000

069104 OCT 20 1987

OR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30559

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTI. DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
			Jonathan	Wendell	Tate	<input checked="" type="checkbox"/>					
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	7 IF UNDER 1 YR. MONTHS	8 IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR	
Male	Black	11 06 1980	6 yrs			10-11 19 87				M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED WIDOWED		9 BALTIMORE CITY OR COUNTY OF DEATH			14 HOUR	
Maryland		U. S. A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		St. Mary's County			7:30P	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital			Student			School			
13a STATE MARYLAND		13b COUNTY Upper Marlboro		13c CITY OR TOWN Upper Marlboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 12704 Whiteholm Dr. 20772			Upper Marlboro Maryland	
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST	MIDDLE		LAST		
George				Tate Jr.		Lucinda	M.		Ashton		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT No. 215-06-2773		Mr. George Tate, Jr.	Upper Marlboro Md. 20772		ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head and neck injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?			
								<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		6:40PM 10-11 1987		Pedestrian run over by pickup truck							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot		21f LOCATION STREET Maryland International Raceway		CITY OR TOWN Budds Creek,		COUNTY St. Mary's County, MD		STATE	
22a I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>						and in my opinion	
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		10-13-87	
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.		ADDRESS		111 Penn St., Balto., MD 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL ADVISER		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		10/17/1987		Potomac Bapt. Ch. Cem.		Hague				Virginia	
24 FUNERAL DIRECTOR NAME						25b DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
NORTHERN FUNERAL HOMES, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						OCT 19 1987		<i>Davidson Landau</i>			

000100-00100

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial/cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 30551												
1 - FOR STATE REGISTRAR			2a DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			
Anne L. Tarmon						10 - 15 - 87			2b HOUR 11:45 p.m.			
3 SEX Female			4 RACE White			5 DATE OF BIRTH MONTH 3 DAY 21 YEAR 1903			6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD			
10 CITY OR TOWN OF DEATH Lexington Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bayside Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY Home			
13a STATE Maryland			13b COUNTY St. Mary's			13c CITY OR TOWN Lexington Pk.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST Duward			MIDDLE			LAST Crawford			15 MOTHER'S MAIDEN NAME FIRST N/A MIDDLE LAST Hammer			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 577-01-7101			17 INFORMANT Sam C. Breckenridge			ADDRESS 3940 Bexley Pl. #103 Marlow Hgts., Md.			
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prob. Metastatic Colon Cancer years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (XX) attended the deceased from August 6, 1985, to October 15, 1987, that (I) (XX) last saw the deceased alive on October 13, 1987, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) did not view the body after death.												
22b SIGNATURE David Allen M.D.						DEGREE MD			22c DATE SIGNED 10-16-87			
(22d PHYSICIAN'S NAME, TYPE OF PRINT)						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e ADDRESS Leonardtown, Md. 20650			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10-16-87			23c NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d LOCATION CITY OR TOWN Alexandria COUNTY Va. STATE			
24 FUNERAL DIRECTOR NAME G.P. Kalas F.H.			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.			25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 19 1987 via David Rader						
BP _____												
DHMH - 16 60M 7/84 (VRA 15, 4)												

1005100-041ea

068959 OCT 20 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that my death certificate be examined within 24 hours after death. If you are unable to do so, please return it to me or to the State Dept. of Health and Mental Hygiene, Division of Vital Statistics, 701 W. Preston Street, Baltimore, Maryland 21201.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG NO 30534		
1. DECEASED NAME (TYPE OR PRINT)	FIRST FLORENCE	MIDDLE IRENE	LAST THOMAS	2a DATE OF DEATH October 8, 1987	MONTH OCT	DAY 8	YEAR 1987	2b HOUR 5:47 P.M.
3. SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH 03	DAY 12	YEAR 18	6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7b CITIZEN OF WHAT COUNTRY? USA	
7a BIRTHPLACE COUNTRY Maryland	7b MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD						
10 CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland	13b COUNTY St. Mary's	13c CITY OR TOWN Leonardtown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE General Delivery 20650				
14. FATHER'S NAME FIRST Vincent	MIDDLE Owens	15. MOTHER'S MAIDEN NAME FIRST Jennie	MIDDLE Cofer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)	16b SOCIAL SECURITY NO. 212 66 6780	17 INFORMANT Frances Willett	ADDRESS Box 80B Lusby, MD 20657					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>hepatic failure</u> } DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus, peripheral vascular disease</u>								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1, OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	21g CITY OR TOWN	21h COUNTY	21i STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						22c DATE SIGNED		
22b SIGNATURE <i>R. Shah</i>						22d DEGREE	22e ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) N. Shah, M.D.						22e ADDRESS Leonardtown, Md. 20650		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 13 Oct '87	23c NAME OF CEMETERY OR CREMATORIAL Charles Mem. Garden	23d LOCATION CITY OR TOWN Leonardtown, St. Mary's, MD	23e COUNTY	23f STATE			
24 FUNERAL DIRECTOR NAME <i>Martell Adams, Aquasco Md 20608</i>	ADDRESS	25a DATE REC'D. BY REGISTRAR OCT 10 1987	25b REGISTRAR'S SIGNATURE <i>John T. [Signature]</i>					

52-05100-370830

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM FIM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30553				
1- STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH ESTIMATED			2b HOUR				
			George M. Tucker						□ MONTH DAY YEAR 10/09/87			M				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) MONTH DAY YEAR		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR		
Male		Caucasian		09/04/17		70 yrs						19		M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED X NEVER MARRIED WIDOWED □ DIVORCED □			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's							
Washington D.C.			U.S.A.						MD							
10 CITY OR TOWN OF DEATH Leonardtown			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT SPECIFICALLY LISTED, GIVE STREET ADDRESS St. Mary's Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR PERSON OF WORKING LIFE) Mechanic			12b KIND OF BUSINESS OR INDUSTRY DC Metro							
13a STATE Maryland			13b COUNTY St. Mary's			13c CITY OR TOWN Mechanicsville			13d INSIDE CITY LIMITS? YES □ NO X			13e STREET ADDRESS Rt 1. Box 384 20659				
14 FATHER'S NAME FIRST Charles			MIDDLE			LAST Tucker			15 MOTHER'S MAIDEN NAME FIRST Mary			LAST Talbot				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b SOCIAL SECURITY NO. N/A			17 INFORMANT Gladys Tucker Same as 13 A-E			ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line 1a, b, c, and d) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic lung carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c			20 AUTOPSY?							
									YES □ NO □							
21a EXTERNAL CAUSE WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE □ NOT WHILE □ AT WORK □ AT WORK □			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that I took charge of the remains described above, held an Autopsy □ Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural death <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
22b ACTUAL SIGNATURE _____															TITLE (SPECIFY) M.D. _____ MEDICAL EXAMINER	
EXAMINER'S NAME James Boyd MD															DATE SIGNED 10/11/87	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/12/87			23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d LOCATION Suitland Prince George's Co. Md.							
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			ADDRESS 6633 Old Alexander Ferry Rd Clinton, Md 20735			25a DATE REC'D. BY REGISTRAR OCT 14 1987			25b REGISTRAR'S SIGNATURE <i>Jean Davidson Landale</i>							

10-21-1988 P-1638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30354			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR			
CATHERINE NMN VITIELLO				OCT. 24, 1987						M			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7/15/1911	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 76 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 HR HOURS MIN							
7a. BIRTHPLACE COUNTRY WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S COUNTY						MD				
10. CITY OR TOWN OF DEATH LEONARDTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS			12b. KIND OF BUSINESS OR INDUSTRY STORE					
13a. STATE MD.	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN LEXINGTON PARK	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE APT. 1-D, JOE BAKER VILLAGE 20653									
14. FATHER'S NAME FIRST JOHN	MIDDLE CATALANO	LAST	15. MOTHER'S MAIDEN NAME FIRST CAROLYN	MIDDLE	LAST FABIANO								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-01-6671	17. INFORMANT DANIEL J. VITIELLO	ADDRESS 6714 Bracken Ct. SPRINGFIELD, VA.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE INFARCT WALL MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ANGINA DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COMPLEX ITANI BLOCK, CONGENITAL HEART FAILURE, shock, Renal Failure, Sepsis													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				21g. CITY OR TOWN	21h. COUNTY	21i. STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 23 1987 to Oct 24 1987 , and that (I) (we) last saw the deceased alive on Oct 23 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>E.W. Westura</i>	22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 24 Oct 87						
22e. ADDRESS LEONARDTOWN, MD. 20650													
23a. BURIAL, CREMATION, REMOVAL CREMATION	23b. DATE 10/25/87	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORIAL SUITLAND	23d. LOCATION CITY OR TOWN P.G. MD.										
24. FUNERAL DIRECTOR NAME W.C. MATTINGLEY FUNERAL HOME, LEONARDTOWN, MARYLAND				25a. DATE REC'D. BY REGISTRAR OCT 27 1987	25b. REGISTRAR'S SIGNATURE <i>John R. Anderson</i>								
DHMH - 16 60M 7-84 (VRA 15, 4)													

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1400 100 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - sign & mail to:

TO FUNERAL DIRECTOR: After this certificate is bearing dated by the attending physician, it may be delivered to the funeral director. The please remove carbon copies. They should be retained 2 years and filed with the State Dept. of Health and Mental Hygiene, Death Record Branch, or removed.

(INFO FOR PART II) If Item 21 is marked off, Item 18 below may apply, or other traumatic event. Medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG NO. / 30553			
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
LORENA Pauline WARD						10-14-1987					7:20AM		
3a SEX	4a RACE	5a DATE OF BIRTH	6a AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR								
female	white	Sept 18 1899	88		YRS								
6b BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8b MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD										
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife											
Charlotte Hall	Charlotte Hall Veterans Home	12b KIND OF BUSINESS OR INDUSTRY -											
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		20714						
MD	Calvert	North Beach			8925 Dayton Ave/20714								
14 Father's NAME	FIRST	MIDDLE	LAST	15 Mother's Maiden Name		FIRST	MIDDLE	LAST					
Frederick	C.		Dodge	Elizabeth		S.		Waltz					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS											
yes	WW I 218 36 3981	Willard C. Ward 4110 1st St., North Beach, MD 20714											
18 CAUSE OF DEATH: Enter only one cause per line for 1a, b, and c. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, CA Uterus</u> APPROXIMATE TIME BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM B PART I OR PART II)			21d LOCATION STREET CITY OR TOWN COUNTY STATE							
21d INJURY OCCURRED <small>at home, work, etc.</small> <small>not white, ap work</small>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)												
22a I certify that (i) (this hospital) attended the deceased from <u>April 17, 1987</u> to <u>Oct 14, 1987</u> , that (ii) (we) last saw the deceased alive on <u>Oct 5, 1987</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated													
22b SIGNATURE <u>J. A. - Hazel - m</u> DEGREE													
22c ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>10-14-87</u>													
22d DECEASED PERSON'S NAME (TYPE OR PRINT) <u>JOHN H. WEISBERG</u> 22e ADDRESS													
23a BURIAL, CREMATION, REMOVAL (TYPE)			23b DATE 10-16-87	23c NAME OF CEMETERY OR CREMATORIUM Mt Harmony UM Church		23d LOCATION OWINGS		23e COUNTY Calvert		STATE MD			
24 FUNERAL DIRECTOR NAME			Rausch FH Owings, MD 20736		25a DATE REC'D BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <u>John Leidson-Randall</u>						

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THE JOURNAL OF CLIMATE

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and company filed by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held until 72 hours after death.

10234 • J. Neurosci., November 18, 2009 • 29(46):10232–10234

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
LAURA GANO YOST						OCTOBER 31, 1987				6:15 AM	
3. SEX FEMALE		4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH JUNE DAY 21, YEAR 1897			6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE STATE OR FOREIGN OHIO		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S				
10 CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S NURSING CENTER			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY 9999				
13a STATE PENNSYLVANIA		13b COUNTY PHILADEL.		13c CITY OR TOWN PHILADELPHIA		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 2031 LOCUST STREET			
14. FATHER'S NAME FIRST STEPHEN		MIDDLE	LAST GANO, JR.		15. MOTHER'S MAIDEN NAME FIRST SOPHIA		MIDDLE CARROLL	LAST ARONS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 143-44-4130			17. PRESENT # SOUTHERN # 1105, 2979		ADDRESS STUART H. YOST, PHILADELPHIA, PA. 19144				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Cerebrovascular Accident</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that <input type="checkbox"/> (this hospital) attended the deceased from 2/27 , 19 84 to 10/31 , 19 87 that <input type="checkbox"/> (we) last saw the deceased at 10/20 , 19 87 and that in <input type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) did not review the body after death											
22b SIGNATURE <i>David C. Allen</i>		22c DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED 11/13/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID C. ALLEN, M.D.		22e ADDRESS LEONARDTOWN, MARYLAND 20650									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11/6/87		23c NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL			23d LOCATION CITY OR TOWN ARLINGTON, ARLINGTON, VA.		23e COUNTY UNTY		
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD		ADDRESS NOV 09 1987			25a DATE REC'D. BY REGISTRAR NOV 09 1987		25b REGISTRAR'S SIGNATURE <i>Edward N. Brinsfield</i>				

COLLECTOR